DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 10/15/2013 FORM APPROVED OMB NO. 0938-0391

STREET ADDRESS, CITY, STATE, ZIP CODE \$129 HILLTOP ROAD EVERETT, WA 98203 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR ISC IDENTIFYING INFORMATION) INITIAL COMMENTS An unannounced Life Safety Code Survey was conducted at Forest View Transitional Health Center, Everett, Washington, on Cotober 15, 2013 by staff from the Washington State Patrol, Fire Protection Bureau, Oak Harbor Detachment. The 2000 existing edition of the Life Safety Code was utilized for the survey in accordance to 42 CFR 483.70: Requirements for Long Term Care. The LTC 70 bed facility with a census of 63, consisted of a Type V-111, 2 story structure, with a basement (used for environmental care purposes) and was built in 1999. The facility is fully sprinkled with an automatic fire alarm system in place. Exit discharge points are to grade and have an all weather surface and lead to a public way. The deficiencies identified during this survey are listed below. Deputy State Fire Marshal STREET ADDRESS, CITY, STATE, ZIP CODE \$129 HILLTOP ROAD EVERETT, WA 98203 ID PREFIX TAG PROMICERS PLAN OF CORRECTION (EACH CORRECTIVE ACTON SHOULD BE CROSS-REFERENCE 10 THE APPROPRIATE DEPCICENCY) K 000 INITIAL COMMENTS K 000 "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Regency Care Center at Forest View does not admit the deficiency listed on this form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency listed on this form the basis for the deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative pr	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SPECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR CROSS-REFERENCED ID THE APPROPRIATE COMMENTAL TAG REGULATORY O			505362		B. WING		10/15/201	3
REGULATORY OR LSC IDENTIFYING INFORMATION) RANGE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY. "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Regency Care Center at Forest View does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY. This Plan of Correction is prepared and submitted as required by law. By submitting this plan of Correction, Regency Care Center at Forest View does to admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." ROSO The LTC 70 bed facility with a census of 63, consisted of a Type V-111, 2 story structure, with a basement (used for any statements, facts, and conclusions that form the basis for the deficiency." ROSO The LTC 70 bed facility with a census of 63, consisted of a Type V-111, 2 story				5129 HI	LLTOP RC	DAD		
An unannounced Life Safety Code Survey was conducted at Forest View Transitional Health Center, Everett, Washington, on October 15, 2013 by staff from the Washington State Patrol, Fire Protection Bureau, Oak Harbor Detachment. The 2000 existing edition of the Life Safety Code was utilized for the survey in accordance to 42 CFR 483.70: Requirements for Long Term Care. The LTC 70 bed facility with a census of 63, consisted of a Type V-111, 2 story structure, with a basement (used for environmental care purposes) and was built in 1999. The facility is fully sprinkled with an automatic fire alarm system in place. Exit discharge points are to grade and have an all weather surface and lead to a public way. The deficiencies identified during this survey are listed below. The facility is not in compliance with the Life Safety Code 2000 Edition as adopted by C.M.S. Deputy State Fire Marshal	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY	/ FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE COMP	X5) PLETION PATE
		An unannounced Leonducted at Foreicenter, Everett, We 2013 by staff from Fire Protection But The 2000 existing was utilized for the CFR 483.70: Requesting the LTC 70 bed factors and the consisted of a Typical basement (used purposes) and was fully sprinkled with in place. Exit dischave an all weather way. The deficiencies id listed below. The facility is not in Safety Code 2000.	Life Safety Code Survest View Transitional Hashington, on October the Washington State reau, Oak Harbor Detredition of the Life Safer survey in accordance durements for Long Teacility with a census of the V-111, 2 story struction of the Life Safer State of the V-111, 2 story struction of the Life Safer State of the V-111, 2 story struction of the Life Safer State of the Safer State of the Safer State of the Life Safer Safer State of the Life Safer State of the Life Safer State of the Life Safer Safe	lealth er 15, e Patrol, achment. ety Code e to 42 rm Care. f 63, ture, with re cility is rm system ade and a public rvey are Life y C.M.S.		submitted as required by law. Plan of Correction, Regency Oview does not admit that the this form exist, nor does the statements, findings, facts, of form the basis for the alleg Center reserves the right to and/or regulatory or administr deficiency, statements, facts, form the basis for the deficiency. K050 Plan to correct identified find An education was performed to Director to ensure Fire Drills a unexpected times under varyin quarterly on each shift. Identification similar situation An education was performed to Director to ensure Fire Drills a unexpected times under varying monthly and on random rotation. Measures to prevent recurre	By submitting this Care Center at Forest deficiency listed on Center admit to any or conclusions that ded deficiency. The challenge in legal rative proceedings the and conclusions that dey." In the Maintenance are held at the geonditions, at least one. The conditions at least one. The challenge in legal rative proceedings the and conclusions that dey." The challenge in legal rative proceedings the and conclusions that dey." The challenge in legal rative proceedings the and conclusions that dey." The challenge in legal rative proceedings the and conclusions that dey." The challenge in legal rative proceedings the and conclusions that dey." The challenge in legal rative proceedings the and conclusions that dey."	8-13
SS=D Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 K 050 tracking fire drills. The Maintenance Director has been signed up for the TELS program to monitor, track, and trend fire drills. Monitor to sustain compliance: The Maintenance Director and/or designee will audit the process of fire drills at unexpected times. Results will be forwarded to Quality Assurance Committee for the next 90 days	SS=D	Fire drills are held varying conditions, shift. The staff is f aware that drills ar Responsibility for p assigned only to co qualified to exercis conducted between announcement manalarms. 19.7.1.2	at unexpected times at least quarterly on a familiar with procedure part of established planning and conduction ompetent persons whose leadership. Where an 9 PM and 6 AM a compute of 19 be used instead of 19 be used inst	under each es and is routine. ng drills is o are drills are oded audible	K 050	tracking fire drills. The Mainte been signed up for the TELS p track, and trend fire drills. Monitor to sustain compliance. The Maintenance Director and audit the process of fire drills a Results will be forwarded to Q Committee for the next 90 day.	ce: /or designee will at unexpected times that the standard of	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) D/ (X6) D/		O CONTROLL (X AOLEA O	MIANVES SIG	` -	making management	10-24 -46-01	12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		& MEDICAID SERV					APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE S		(X3) DATE SU COMPLE	SURVEY	
		505362		B. WING		10/18	5/2013
	ROVIDER OR SUPPLIER VIEW TRANSITION	VAL HEALTH CENT	5129 Hi	RESS, CITY, S LLTOP RO TT, WA 98			
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K 050	Continued From pa	age 1		K 050	K076		11-8-13
K 076 SS=D	Based on record re assure that the LTC to respond to fires. residents to smoke Findings include: An examination of ton October 15, 201 the fire drill records 1. 3rd qtr, 2013 (m. These findings well Maintenance Direct NFPA 101 LIFE SA Medical gas storage protected in accord Standards for Healt (a) Oxygen storage 3,000 cu.ft. are end separation. (b) Locations for su	FETY CODE STANE and administration ance with NFPA 99,	d to y trained beed records ed that for: he DARD areas are than	K 076	Plan to correct identified findings: Oxygen Cylinders were immediately second floor and first floor. Identification similar situation: An audit was complete of the Oxygen the facility to ensure proper storage. Measures to prevent recurrence: An education has been performed to staff on securing Oxygen Cylinders of second floor. A random audit will be completed by Maintenance Director and/or designe proper storage and educate when nec. Monitor to sustain compliance: A random audit will be completed by Maintenance Director and/or designe proper storage. Results will be forwad Quality Assurance Committee for the days.	the licensed on the first and the to ensure essary.	

This Standard is not met as evidenced by:

Based on observation and staff interview the facility failed to maintain medical gas storage in accordance to NFPA 99,4-3.1.1.2. This has the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
505362		B. WING		10/1	5/2013		
	ROVIDER OR SUPPLIER				TATE, ZIP CODE	-1	****
FOREST	VIEW TRANSITIO	NAL HEALTH CENT		ILLTOP RO			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 076	Continued From page			K 076			
		ind explosive hazard		:	K130		11-8-13
		ils potentially expose	ď	j	Plan to correct identified findings:		(1°0")
	residents to a missile hazard during fire conditions. Findings include: During the facility tour on October 15, 2013 from 9:30 AM AM to 1:45 PM. It was observed that: 1. 2nd floor oxygen storage room - 3 cylinders unsecured 2. 1st floor oxygen storage room - 4 cylinders unsecured.				CO 2 Detector in hallway of second finstalled	loor was	
				7700	CO2 2 Detector in hallway of first flo	or was	
					CO2 detector in Resident Room 102	was installed	
					Identification similar situation:		
	These findings wer Maintenance Direct	e acknowledged by tor.	he facility	·	An education will be performed to sta CO2 Detectors installed, the sound ar procedure in case alarms.	aff regarding ad the	
K 130 SS=D	NFPA 101 MISCELLANEOUS			K 130	Measures to prevent recurrence:		
35=U	OTHER LSC DEFI	CIENCY NOT ON 27	86	·	Battery Power checks will be perform on CO2 detectors and reported to Qua Assurance Committee for 90days.	ned monthly ality	
	This Standard is not met as evidenced by: Based on observations, the facility did not have Carbon Monoxide Detectors installed in the building in accordance with NFPA Standard 720 2012 edition. This has the potential of having a leak with no detection that would expose			· ommenderstates	A random audit will be completed by Maintenance Director and/or designe staff education and awareness of CO2 the next 30days.	e to ensure	r
					Monitor to sustain compliance:		
	residents, visitors a	esidents, visitors and staff to a hazardous nvironment. The findings are as follows: Ouring the facility tour on October 15, 2013 from :30 AM to 1:45 PM the following deficiencies			Battery Power checks will be perform on CO2 detectors and reported to Qua Assurance Committee for 90days.		
					A random audit will be completed by Maintenance Director and/or designed staff education and awareness of CO2 and forwarded Quality Assurance Co	e to ensure 2 Detectors	
	 No CO detector coverage in the hallway of the second floor No CO detector coverage in the hallway of the 				the next thirty days.		
	first floor.	coverage in the hally coverage in Residen					

(X2) MULTIPLE CONSTRUCTION



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

505362

B. WING_

10/15/2013

NAME OF PROVIDER OR SUPPLIER FOREST VIEW TRANSITIONAL HEALTH CENT

STREET ADDRESS, CITY, STATE, ZIP CODE

5129 HILLTOP ROAD EVERETT, WA 98203

	EVEF	RETT, WA 98	2203	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 3 102	K 130	K144	
	These findings were acknowledged by the Maintenance Director.		Plan to correct identified findings:	E1-8-11
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 144	An education was performed to the Maintenance Director to ensure Emergency Power test monthly are performed.	
33-17	Generators are inspected weekly and exercised under load for 30 minutes per month in		Identification similar situation:	
·	accordance with NFPA 99. 3.4.4.1.	7	An education was performed to the Maintenance Director to ensure monthly Emergency Power testing are performed.	:
			Measures to prevent recurrence:	
		de la constitución de la constit	Maintenance Director has been provided forms for tracking Emergency Power Testing. The Maintenance Director has been sign up for the TELS program to monitor, track and trend.	
	This Standard is not met as evidenced by: Based on record review and staff interview, the	-	Monitor to sustain compliance:	
	facility failed to assure that emergency power was available during primary power outage in accordance with NFPA 99, 3-4.4.2 requiring documentation of testing, maintenance and repairs of the generator. This potentially affected all residents to loss of illumination of exit egress, fire and smoke alarms during a power outage. Findings include:		The Maintenance Director and/or designee will audit the process of Emergency Power Testing Results will forwarded to Quality Assurance Committee for the next 90 days.	
	1. During a record review of the generator maintenance log on October 15, 2013 at 12:30 PM, the facility failed to maintain a proper log showing that the generator had been placed under a load in the past 12 months for : May, June, July, August, September 2013			
	2. During a record review of the generator maintenance log on October 15, 2013 at 12:40 PM, the facility failed to maintain a proper log showing that the generator had been inspected			
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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 10/15/2013 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 **IDENTIFICATION NUMBER:** COMPLETED 505362 B. WING 10/15/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE FOREST VIEW TRANSITIONAL HEALTH CENT **5129 HILLTOP ROAD EVERETT, WA 98203** SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY** K 144 Continued From page 4 K 144 K147 weekly for the past 12 months for: May, June, 11-8-13 July, August, September 2013. Plan to correct identified findings: This deficiency was acknowledged by the Second Floor Soiled Utility room by Resident Maintenance Director. Room 202 hand cleaner was removed. K 147 NFPA 101 LIFE SAFETY CODE STANDARD K 147 Hand Sanitizer was removed in Social Worker SS=D Office. Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Multi Plug device was removed from the Kitchen Manager Office. Extension Cord was removed and multi plug This Standard is not met as evidenced by: adapter was removed from Laundry Area. Based on observations, the facility failed to maintain proper electrical conditions per NFPA Identification similar situation: 70, National Electrical Code. This has the An audit was completed of the facility to ensure potential to expose staff and patients to a fire hand sanitizers are in proper locations, Multi plugs environment. The findings are as follows: are properly used, and extension cords not in usage During the facility tour on October 15, 2013 from Measures to prevent recurrence: 9:30 AM to 1:45 PM the following deficiencies were identified: Maintenance Director and/or designee will perform an education to staff to ensure hand sanitizers are 2nd floor Soiled utility room by Res Room 202 in proper place, Multi plugs are properly used, and - hand cleaner above electrical source extension cords not in usage. 2. Social Worker Office - hand sanitizer above The Maintenance Director has initiated the TELS electrical source program to monitor, track, and trend. 3. Kitchen Mgr Office - multi plug device plugged into multi plug device Monitor to sustain compliance: 4. Laundry - extension cord powering a multi plug adapter The Maintenance Director and/or designee will perform random audits to ensure hand sanitizer is These findings were acknowledged by the in proper location, Multi plugs are properly used. Maintenance Director and extension cords are not in use in the facility. Results will forwarded to Quality Assurance



Committee for the next thirty Days.

CELIVELENCE	FOR MEDICARE & MEDICAID SERVICES		A FORM					
NO HARM	NT OF ISOLATED DEFICIENCIES WHICH CAUSE WITH ONLY A POTENTIAL FOR MINIMAL HARM	PROVIDER #	DATE SURVEY COMPLETE:					
FOR SNFs	AND NFs	505362 10/15/2013						
	PROVIDER OR SUPPLIER VIEW TRANSITIONAL HEALTH CENTER	STREET ADDRESS, CITY, STA 5129 HILLTOP ROAD EVERETT, WA. 98203	ATE. ZIP CODE					
D PREFIX ΓAG	SUMMARY STATEMENT OF DEFICIENCIES	EVERE11, WA. 76203						
K 012	NFPA 101 LIFE SAFETY CODE STANDARD							
	Building construction type and height meets one of the f	following. 19.1.6.2, 19.1.6.3, 19.	1.6.4, 19.3.5.1					
	This Standard is not met as evidenced by:  Based upon observations and staff interviews on Octobe maintain fire resistive construction of the building capab. This could allow the toxic product of combustion to move compartment which would endanger the residents, staff a	ole of resisting the passage of smo	oke and fire into other compartments.  access corridor and the smoke					
	The findings include, but are not limited to:  1. The wall behind the door on the first floor of the back stairwell has a hole approximately the size of a baseball due to door handle.  The above was discussed and acknowledged by the Maintenance Director.							
K 018	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6,3.6 are permitted. 19.3.6.3							
	Roller latches are prohibited by CMS regulations in all health care facilities.							
	This Standard is not another address the							
**************************************	This Standard is not met as evidenced by:  Based on observation and staff interview the facility failed to assure that door openings closed to resist the passage of smoke corridors. This potentially exposed residents to a smoke/fire environment. Findings include:							
	During the facility tour on October 15, 2013 from 9:30 AM to 1:45 PM it was observed that the following doors did not close, latch or open properly when tested:							
	2nd floor nurses station work office - wedged open		R					
ny deficien	ary statement ending with an acterisk (*) denotes a deficiency w	high the inctitution may be averaged i	Serve composing amountains it is determined					

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

The above isolated deficiencies pose no actual harm to the residents

	IT OF ISOLATED DEFICIENCIES WHICH CAUSE WITH ONLY A POTENTIAL FOR MINIMAL HARM AND NFs	PROVIDER # 505362	DATE SURVEY COMPLETE: 10/15/2013					
NAME OF I	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, S	TATE, ZIP CODE					
	VIEW TRANSITIONAL HEALTH CENTER	5129 HILLTOP ROAD EVERETT, WA. 98203						
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES							
K 018	Continued From Page 1							
	<ul><li>2. Social worker office - wedged open</li><li>3. 1st floor nurses station work office - wedged open</li></ul>							
-	These findings were acknowledged by the facility Maintenance Director.							
CARALAMA AND PROPERTY PER	All three deficiencies were corrected immediately							
K 064	NFPA 101 LIFE SAFETY CODE STANDARD							
	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10							
	This Standard is not met as evidenced by: Based on observation and record review, the facility faile delays a quick response to contain a fire from spreading, During the facility tour on October 15, 2013 from 9:30 A where the top of the fire extinguisher exceeded 5 feet about 1. Kitchen store room The Maintenance Director acknowledged the findings.	exposing residents to fire in the M to 1:45 PM, observed fire e	e environment.					
			æQ					

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

The above isolated deficiencies pose no actual harm to the residents

#### K012

Plan to correct identified findings: The wall behind the door on the first floor was repaired.

**Identification similar situation:** An audit was completed by the Maintenance Director to ensure no holes were present in the drywall in the facility.

Measures to prevent recurrence: Maintenance Director and/or designee will perform an audit of the facility walls to ensure no other holes are present in the dry wall.

Monitor to sustain compliance: The Maintenance Director and/or designee will perform random audits to ensure no holes in dry wall. Results will be forwarded to Quality Assurance Committee for the next thirty Days.

#### K018

Plan to correct identified findings: Wedges were removed from Social Worker Office, 1st Floor Nurses Station work office, 2nd Floor Nurses Station Work Office.

**Identification similar situation:** An audit was completed of the facility to ensure wedges are not being used in doors.

Measures to prevent recurrence: Maintenance Director and/or designee will perform an education to staff regarding wedges are not used in doors

Monitor to sustain compliance: The Maintenance Director and/or designee will perform random audits to ensure no wedges are in use at the facility. Results will forwarded to Quality Assurance Committee for the next thirty days.

#### K064

Plan to correct identified findings: Fire Extinguisher in the kitchen was moved down to proper level in kitchen store room.

**Measures to prevent recurrence:** An audit was performed in the facility to ensure Fire Extinguishers in facility are at proper level.

Monitor to sustain compliance: The Maintenance Director will report findings of audit of fire extinguishers to the proper levels to the QA/QI Committee. Results will forwarded to Quality Assurance Committee for the next thirty Days.

